



## Comorbidity in youth with specific phobias: Impact of comorbidity on treatment outcome and the impact of treatment on comorbid disorders<sup>☆</sup>

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### ABSTRACT

The purpose of the present study was twofold. In an analysis of data from an existing randomized control trial of brief cognitive behavioral treatment on specific phobias (One-Session Treatment, OST; Ollendick et al., 2009), we examined 1) the effect of comorbid specific phobias and other anxiety disorders on treatment outcomes, and 2) the effect of treatment of the specific phobia on these co-occurring disorders. These relations were explored in 100 youth presenting with animal, natural environment, situational, and “other” types of phobia. Youth were reliably diagnosed with the Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent versions (Silverman & Albano, 1996). Clinician severity ratings at post-treatment and 6-month follow-up were examined as were parent and child treatment outcome satisfaction measures. Results indicated that the presence of comorbid phobias or anxiety disorders did not affect treatment outcomes; moreover, treatment of the targeted specific phobias led to significant reductions in the clinical severity of other co-occurring specific phobias and related anxiety disorders. These findings speak to the generalization of the effects of this time-limited treatment approach. Implications for treatment of principal and comorbid disorders are discussed, and possible mechanisms for these effects are commented upon.

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Numerous randomized control trials (RCTs) with Cognitive Behavioral Therapy (CBT) for the treatment of anxiety and phobic disorders in youth have been published in recent years. Collectively, these studies indicate significant reductions in the clinical severity of these disorders and reductions in clinical diagnoses for 50–70% of the treated youth in comparison to 10–30% of youth in waitlist or comparison control conditions (see In-Albon & Schneider, 2007; Ollendick, King, & Chorpita, 2006; Silverman, Pina, & Viswesvaran, 2008, for recent reviews). A common theme throughout these RCTs are the high rates of comorbidity in the study samples, with the most common co-occurring disorders being other anxiety and phobic disorders, but also mood and disruptive behavior disorders. Given this high rate of comorbidity, one question that has received attention in recent years is whether the presence of comorbidity compromises treatment outcomes.

Ollendick, Jarrett, Grills-Tauchel, Hovey, and Wolff (2008) recently reviewed the literature on the influence of comorbidity on treatment outcomes for youth with a variety of childhood disorders including the anxiety disorders. Of the 16 RCTs using CBT for anxiety disorders that addressed the effects of comorbidity on treatment outcomes, 15 failed to find any significant differences on post-treatment outcomes due to the presence of comorbidity. For the most part, the types of comorbidity examined in these studies consisted of other phobic and anxiety disorders. Only one of the 16 RCTs reported significant differences in outcomes for participants with comorbid disorders (Berman, Weems, Silverman, & Kurtines, 2000). In that study, differences in successful outcomes were found in the treatment of anxious youth who were comorbid with mood disorders but, as with the other studies, not for youth who were comorbid with other anxiety and phobic disorders.

A second question is what is the effect of treatment of an anxiety or phobic disorder on comorbid disorder(s) that are present prior to the beginning of treatment but not specifically targeted during treatment? To date, this question has received very little attention. However, two studies have examined this question with phobic and anxiety disorders in youth and they provide initial support for the salutatory effects of treatment on untreated, untargeted disorders. With generalized, social, and separation anxiety disorders in youth,

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Kendall, Brady, and Verduin (2001) reported that CBT treatment produced positive effects not only on the primary disorders but also on non-primary co-occurring anxiety disorders. Similarly, in the treatment of specific phobias in youth, Öst, Svensson, Hellström, and Lindwall (2001) reported that brief CBT (One-Session Treatment, OST) resulted in reductions in comorbid phobic disorders. Thus, initial findings provide limited support for the positive effects of treatment on comorbid disorders, at least when the comorbid disorders fall in the same class of disorders (e.g., treatment of specific phobias results in changes in untreated phobias and treatment of generalized, social and separation anxiety disorders result in changes in these disorders).

The purpose of the present study was twofold. In an analysis of data from an existing RCT on the treatment of specific phobias in youth (OST; Ollendick et al., 2009), we examined 1) the effect of comorbid specific phobias and other anxiety disorders (e.g., generalized, social and separation anxiety disorders) on treatment outcomes, and 2) the effect of successful treatment of the specific phobias on co-occurring phobic and other anxiety disorders. We predicted that comorbid phobic disorders would not adversely affect treatment outcomes but that comorbid anxiety disorders (generalized, separation, and social anxiety disorders) would adversely affect treatment outcomes at post-treatment and 6-month follow-up; moreover, we predicted that the treatment of the targeted specific phobia would lead to reductions in the severity of co-occurring phobias but *not* reductions in the severity of comorbid anxiety disorders. As such, we examined the specificity and generalization of this brief cognitive behavioral treatment to untreated specific phobias and untreated anxiety disorders.

## Method

### Participants

Children and adolescents were recruited through referrals from child mental health services, school health services, family medical practices, and newspaper advertisements in Stockholm County, Sweden and the New River Valley and Roanoke Valley areas of southwestern Virginia. For a full description of the original study's inclusion criteria, design, and procedures please see Ollendick et al. (2009).

The sample for the current study was drawn from the original sample of participants ( $N = 196$ ) who were included in the Ollendick et al. (2009) RCT and who were randomized to the OST condition ( $N = 100$ , 50 from Sweden and 50 from Virginia; the remaining 96 youth were randomized to an Education Support control condition). The sample consisted of youth (58% male) with a mean age of 10.21 years ( $SD = 2.26$ ). Ninety-three percent of the sample was Caucasian, 3% were African-American, 2% were Hispanic, and 2% were of other ethnic backgrounds. Of the 100 youth, 54 presented with an animal phobia (e.g., dogs, bees), 25 with a natural environment phobia (e.g., storms, heights), 13 with a situational phobia (elevators, enclosed places), and 8 with an "other" phobia (e.g., costumed characters, vomiting). The blood-injection-injury type was excluded due to differences in physiology and the necessity for supporting medical personnel for treatment purposes.

Comorbidity was defined as fulfilling another DSM-IV diagnosis according to semi-structured diagnostic interviews (Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent versions, ADIS-C/P; Silverman & Albano, 1996) with a clinician severity rating (CSR) of 4 or above. Relative impairment of various diagnoses, as determined by CSRs, was used as the basis for assigning primary versus secondary diagnoses (Silverman & Albano, 1996). Two groups were formed: 1) No comorbid diagnosis group ( $N = 50$ ) and 2) Comorbid diagnosis group ( $N = 50$ ). For

the 50 in the comorbid group, 21 had comorbid phobia(s) only (3 of the 21 had two co-occurring phobias) with no other co-occurring disorders; whereas, the remaining 29 had at least one comorbid anxiety disorder in addition to their primary phobia (14 had GAD; 10 had Social Phobia, 4 had Separation Anxiety Disorder, and 1 had Anxiety Disorder NOS). In addition, 2 of the 29 who had comorbid anxiety disorders had ADHD as a non-primary co-occurring disorder (see Jarrett, Wolff, & Ollendick, 2007, for the reliable and valid use of the ADIS-C/P with ADHD). None of the youth had co-occurring mood disorders or other disruptive behavior disorders. Thus, the bulk of the co-occurring disorders were other phobic and anxiety disorders.

### Measures

#### Diagnostic assessment

The Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent versions (Silverman & Albano, 1996) were administered by trained-to-criterion graduate student clinicians enrolled in doctoral programs in clinical psychology at the respective sites. One clinician interviewed the child (ADIS-C) while another clinician simultaneously interviewed the primary caregiver (ADIS-P, 94% mothers). The outcomes of these two interviews were discussed with the project directors during weekly supervision sessions at each site to arrive at consensus diagnoses and clinician severity ratings. To assess reliability of the diagnoses, 20% of the video taped interviews were randomly selected and reviewed by independent trained clinicians. Assessors were blind to treatment condition, both prior to and following treatment. Using Cohen's kappa, agreements on diagnoses were .94 and .87 on primary and secondary diagnoses.

#### Clinician severity rating (CSR)

As part of the diagnostic interview with the ADIS-C/P, the clinicians rated the severity of the child's targeted phobia and the co-occurring disorders on a 0–8 scale, where 0 = no symptoms, 2 = mild, 4 = moderate, 6 = severe, and 8 = very severe. Assessors were blind to treatment condition, both prior to and following treatment. Interclass correlation coefficients were computed on 20% of the sample and indicated good reliability for the CSRs across primary and secondary diagnoses ( $ICC = .72$ ).

#### Treatment outcome satisfaction scale (TOSS)

Treatment outcome satisfaction was assessed by a 3-item scale devised for this study. Parents and the child independently rated how (1) fearful, (2) avoidant, and (3) interfering the fears were for them following treatment. These items were rated on a 0–8 scale with 0 indicating 'not at all' and 8 indicating 'very, very much.' The three items were summed and the item mean was calculated separately for parents and children. A mean item score below 3.5 was used to indicate clinically significant improvement (little to very little fear/avoidance/interference; see Ollendick et al., 2009). This measure was obtained only at post-treatment.

#### Procedure and treatment

Youth and their families participated in two pre-treatment sessions. In the first session, the parent signed an informed consent form and the child provided signed assent, with both forms approved by our respective Institution Review Boards. During this assessment session, the ADIS-C/P (child and parent version) was administered. During the second assessment session, both the child and parent completed a variety of questionnaires. If the child was judged to fulfill the DSM-IV criteria and was appropriate for treatment, the therapists, who were trained doctoral student

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